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The Global Challenge of HIV/AIDS: The Impact of Gender Disparities on the Growth and Spread of HIV/AIDS

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Introduction

Ladies and gentlemen, I'd like to thank the International Film and Television Exchange and the Bi-Cameral Congressional Human Rights Caucus for inviting me here to speak today. Today's screening of the film "In Women's Hands" is a powerful reminder of why the international community is fighting to stop the spread of HIV/AIDS, and by doing so to help mitigate the profoundly negative HIV/AIDS impact on women.

Before I begin, I'd also like to congratulate the Bi-Cameral Congressional Human Rights Caucus for its very recent expansion into the U.S. Senate. Your leadership on human rights issues around the world is extremely important. You undoubtedly know that through the President's Emergency Plan for AIDS Relief (PEPFAR) the U.S. is the leading international donor on HIV/AIDS assistance. We are the leading donor to the Global Fund. We are bringing ever more HIV/AIDS partners into the fold to prevent the spread of the disease, to deliver lifesaving drugs and supplies to the field for those living with and affected by HIV/AIDS, and to provide compassionate palliative care. The added work of the Bi-Cameral Congressional Human Rights Caucus, particularly on HIV/AIDS, brings more impact and depth to our leadership in this area.

I also want to take a moment to welcome all of my distinguished colleagues on the panel for today. I look forward to hearing others' remarks about the powerful work they are doing in the area of gender disparities and HIV/AIDS. Speaking of new partners, I would like to particularly recognize Dr. Zeda Rosenberg, CEO of the International Partnership for Microbicides. IPM is the newest USAID partner working on microbicide research and development and I want to welcome her to the community of USAID cooperating agencies.

Overview

The spread of HIV/AIDS invariably involves a heavy toll on human lives and it is only right that the global community is seeking the most effective ways to address this complex epidemic. Of particular concern is the impact of the epidemic on women in many parts of the world. In 2005, the UN estimated that 17.5 million adult women were living with HIV - one million more than in 2003. Although more men than women are infected with the virus globally, in sub-Saharan Africa, home to more than 60% of the 40.3 million people living with HIV, about 57% of the adults living with HIV are women. In all, an estimated 77% of all women living with HIV reside in sub-Saharan Africa.[1]

To better address the impact of the epidemic on women, we need to focus our attention on the factors that drive the epidemic. We know that the epidemic is shaped by human behavior and that the vast majority of new infections are related to sexual behavior. We also know that behavior change has occurred in many settings in which we have observed declines in HIV. I will site examples from Uganda, Cambodia, Zimbabwe, and Kenya.

In Uganda, HIV prevalence decreased dramatically in the past decade from approximately 15% to 5%. [2] The most dramatic declines in the rate of new infections appear to have occurred in the late 1980s and early 1990s, and were primarily associated with reductions in sexual partners.[3] The proportion of men in Uganda with one or more casual partners in the previous year decreased from 35% in 1989 to 15% in 1995, and the proportion of women reporting one or more casual partners declined during the same period from 16% to 6%.[2] The proportion of men with three or more non-regular partners in the previous year dropped from 15% in 1989 to 3% in 1995.[2]

On the other side of the globe in Cambodia, adult prevalence has also decreased significantly from 4% in 1999 to 2.6% by the end of 2002. Early in Cambodia's epidemic, the government recognized prostitution as a source of many new infections, and leveraged vigorous prevention efforts to address this context based on the successful models developed in neighboring Thailand. As a result, declines in HIV prevalence among prostitutes were even more dramatic, falling from 42.6% in 1998 to 28.8% in 2002. The proportion of brothel-based prostitutes reporting consistent condom use rose from 51.3% in 1989 to 89.8% in 2002. In addition, fewer men visited the brothels. For example, the proportion of urban police reporting having paid for sex decreased from 75.8% in 1997 to 32% in 2001.[4]

In Kenya, according to Ministry of Health estimates, HIV prevalence in pregnant women dropped from a high of about 13.4% in 1998 to approximately 7.5% in 2004.[5] The latest national demographic and health survey in Kenya, conducted in 2003, found an overall adult HIV prevalence of 7%.[6] An inspection of the behavioral data from the 1998 and 2003 demographic and health surveys suggests that a fairly comprehensive set of changes in behavior may be associated with these declines. In terms of abstinence and delay of sexual debut, the proportion of 15 - to 24-year-old young men who had sex in the past year declined from 32% in 1998 to 21% in 2003. This proportion also declined for the same period in 15- to 24-year-old young women, from 56% to 41%. Fidelity and reductions in sexual partners likely played important roles as well, as the proportion of adult men with multiple sexual partners in the past year declined from 30% in 1998 to 17% in 2003, and the proportion of adult women with multiple sexual partners in the past year fell from 4% in 1998 to 2% in 2003.[7]

This past February, a new study in the journal Science reported on declines in HIV in Eastern Zimbabwe. Most notably, HIV prevalence among 17- to 29-year-old males dropped significantly from 10.6% during the baseline period of 1998-2000 to 8.1% during the follow-up period of 2001-2003, and the rates among 15- to 24-year-old women dropped even more appreciably during the same period from 15.9% to 8%. The article concluded that increases in abstinence, reductions in sexual partners, and some increases in consistent condom use with casual partners were associated with the declines in HIV. The proportion of 15- to 17-year-old young women who had sex in the past year fell from 21% during the baseline period to 9% in the follow-up period, and the proportion of 17- to 19-year-old young men who had sex in the past year fell from 45% to 27% between these two periods. During the same timeframe, the proportion of women who had new sexual partners in the past year fell from about 19% to 13% and the proportion who had a recent casual sex partner fell from 7.5% to 5.9%. Among men, the proportion who had new sexual partners in the past year fell from about 49% to 33%, and the proportion who had sex with a casual partner in the past month fell from 25.9% to 13.2% during this period. In addition, while rates of consistent condom use with regular partners did not increase, rates of consistent use with casual partners among women did, from 26.2% to 36.5% between the two survey rounds.[8]

With respect to the recent encouraging news from Zimbabwe and Kenya, UNAIDS Executive Director Dr. Peter Piot noted the following in his official remarks on the occasion of the launch of UNAIDS 2005 AIDS Epidemic Update: "The declines in HIV rates have been due to changes in behavior, including increased use of condoms, people delaying the first time they have sexual intercourse, and people having fewer sexual partners."[9]

The U.S. Government recognizes, however, that facilitating behavior change is a complex task. If we are to slow significantly the spread of the dread pandemic of HIV/AIDS, we must address the challenges related to gender equity, violence, and social expectations and norms, and get to the heart of much of the behavior which must be altered. Let me say very emphatically that the U.S., through the President's Emergency Plan, is demonstrating true innovation and leadership in the area of gender disparities on the growth and spread of HIV/AIDS. We embrace a comprehensive approach that is strategic in nature. We are working on creating an enabling environment where behavior change will not just be called for, but be possible. We are taking on the structural and cultural constraints that impede women's abilities to prevent and mitigate HIV/AIDS. We face these challenges as a global community and I would like to take the opportunity this morning to discuss these important issues, the challenges, and some of the ways that the U.S. Government is addressing them.

First, I'd like to begin with a success story - one that many of you may have already heard about. Earlier this month,

First Lady Laura Bush hosted a group of very positive and empowered women from South Africa. These women are part of an organization called Mothers to Mothers-To-Be. Through the Emergency Plan, USAID has funded this unique group, which is a support network for pregnant women who have just learned their HIV status. Here is how it works: a woman goes to a hospital or clinic - she may be younger or older. She learns she is pregnant, or maybe she already knows she is pregnant. She also learns she is HIV positive, or perhaps she already knows this as well. A female mentor who works for Mothers to Mothers-To-Be befriends this young woman, teaching her how to live with HIV. This program bridges the gap between awareness and education. It addresses issues of stigma. It gives women hope and a future. Ideally, it can stop the cycle of HIV/AIDS by keeping an HIV-positive mother from passing the disease onto her unborn baby. This is exceptionally good news. However, at its core, this program addresses a fundamental gender disparity issue: access - access to information, resources, and healthcare. This program tackles this issue, and it delivers. This is why we are here today. To talk about how we can, as an international community, keep delivering women from the other disparities that impact the growth and spread of HIV/AIDS.

Male Norms and Behaviors

Another critical topic to discuss is male norms and behaviors. Working with boys and men is an integral part of our HIV programs and efforts to get at the root causes of vulnerability to HIV/AIDS. Socially-structured norms and expectations related to men's behavior and roles; the acceptance of casual sex and multiple sexual partnerships; the encouragement of older men to have sexual relations with much younger women; viewing men in the household as the sole decision-maker; and the likelihood of males to engage in substance use or other risky sexual behavior, all help fuel the epidemic and put both men and their partners at risk. Furthermore, men's reluctance to seek health services limits their ability to learn their HIV status, and limits the likelihood that they will be challenged to change their risky sexual behavior and adopt preventative behaviors. The challenge of influencing male norms and behaviors requires acknowledgement that all-too-often men's norms and behaviors are detrimental not just to their own health, but to their partners. I would like to highlight a few USG programs that work with boys and men.

In South Africa, the Emergency Plan supports a very successful male involvement program known as "Men as Partners." In addition to dealing with HIV/AIDS prevention issues that include masculinity, stigma, and domestic violence, men are encouraged to assume a larger share of responsibilities for family and community care by spending more time with their children, mentoring young boys in the community, and visiting terminally ill AIDS patients.

In Zambia, the U.S. is working with the Zambian Defense Force to train peer educators and commanding officers to raise awareness among men in the military about the threat posed by HIV/AIDS, and to enlist their support in addressing it. Training workshops cover basic facts about HIV/AIDS and its impact, including transmission, prevention, stigma, sexuality, gender, positive living, counseling and testing, and care.

In Uganda, the Empowering Africa's Young People Initiative (EAYPI) includes a focus on masculinity and gender norms. Community advocacy and sensitization meetings are conducted for both younger and older males. For younger males, the focus is on challenging norms about masculinity, challenging the acceptance of early sexual activity and multiple sexual partners for boys and men, and challenging the dangerous and abusive practice of transactional sex. As for older males, the focus is on supporting counseling, peer education, community interventions, and the ending of the dangerous and abusive practices of transactional and cross-generational sex.

The Necessity of Addressing Gender to Transcend the "Culture Wars" in HIV Sexual Prevention

Dealing with the sexual spread of HIV requires coming to understand that fundamental human rights and gender issues, not just health issues, are at stake.

We can only move forward by fully embracing the comprehensive PEPFAR commitment to preventing sexual transmission of HIV. **The "ABC" (abstinence or delay of sexual debut, being faithful, and the appropriate and consistent use of condoms) must be lifted out of the mire of American and international "culture wars" and understood much more broadly.** "Abstinence," must be understood as a "right" of girls and women, and boys and girls ought not to be stigmatized for waiting until they are married or older to engage in sex. "Being faithful" should be understood as a gender equity issue, requiring an end to putting female partners at risk, and an end to unacceptable "double-standards." And condoms are an imperative in discordant couples and where risky behavior is involved. It should be noted, however, that thus far our programs seem to have had limited success in achieving consistent condom use in regular and marital relationships.[10] Thus, it is all the more important to find ways to persuade men to be "faithful" to their spouses or to a single partner.

There is no place for putting our heads in the sand with respect to any of the important interventions of "A," "B," or "C."

Cross-generational sex and transactional sex

Cross-generational and transactional sex are major contributors to the epidemic. In sub-Saharan Africa, young women between the ages of 15 and 24 years old are at least three times more likely to be HIV-positive than young men suggesting that cross-generational sex is fueling many infections in girls and young women.[11] Women's and girls' relative lack of power and financial independence increases the risk that they may feel compelled to engage in transactional and/or cross-generational sex and that they are often not able to negotiate whether they have sex at all, and if so, under what conditions sexual intercourse will occur. Women too frequently are unable to insist on use of contraceptive interventions or condoms. In most settings, it is clear that much cross-generational sex is transactional in nature - fueled by poverty and financial need, by social norms and expectations, or both.

Tackling the tough challenges related to cross-generational sexual relationships means not only supporting outreach activities with youth and livelihood option for girls, but working with men and communities to transform the norms that uphold these types of relationships as acceptable.

Gender-based violence

Perhaps one of the most complex issues we encounter is gender-based violence. It is a pervasive human rights and public health problem that impacts women's and girls' vulnerability to HIV/AIDS. Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime.[12] Between 7% and 48% of girls and young women age 10 - 24 years report their first sexual encounter as coerced.[13] Gender-based physical and sexual violence (GBV) is directly connected to an increased risk of HIV. A very serious form of GBV is the trafficking of persons for sexual exploitation. It is a human rights abuse on a global scale and the USG has made a commitment to its end. The USG helps communities recognize and address sex trafficking of women and girls. There is no question but that the international demand for prostitution is a huge driver in international trafficking in persons, and its attendant spread of HIV/AIDS. Whatever one's personal views may be about whether there ought to be a "right" to prostitution in some cases, there can be no question that internationally prostitution is intimately connected to trafficking, horrendous human rights violations, crime, and significant health risks. I have found broad consensus on the importance of eliminating gender-based violence, and any progress in this area will cut down on trafficking in persons and the spread of HIV/AIDS.

As noted earlier, for many women, actual violence and the fear of sexual coercion and violence often precludes the option of abstinence, or the ability to negotiate condom use or fidelity, or to refuse sex with their partner. Violence may prevent women from accessing appropriate HIV information, being tested, disclosing their status, accessing services for their infants, and accessing treatment, care and support. By not disclosing their status for fear of stigma and discrimination, the effectiveness of efforts to confront the global epidemic is hindered and creates a climate for further HIV transmission. In studies from sub-Saharan Africa that examine violence as an outcome of women's HIV status disclosure, among women who do disclose their HIV status, between 3% and 15% report negative reactions including blame, abandonment, anger, and violence.[14] In a Tanzania study of women accessing VCT services, women reported fear of violence and abandonment as primary reasons for not disclosing their serostatus to their partner.[15] Fear of violence may be a greater deterrent than violence itself.

The U.S. government is addressing this issue by, among other activities, encouraging education for both men and women and integrating counseling and testing sites with PMTCT services. I would like to highlight a couple of examples. "Lifeline Childline" program in Namibia address roots of gender violence. It uses age-appropriate messages to teach girls and boys about HIV/AIDS, sexual abuse, domestic violence, and the resources available to vulnerable children through specialized counseling and other services.

In Vietnam, the "Men in the Know" program provides training though workshops for men to promote safer sex within relationships and challenges the social norms prevalent in some communities that contribute to the sexual abuse of women. In both Zambia and South Africa, U.S. Government partners are assisting women with concerted efforts to scale up sexual violence prevention services and post-exposure prophylaxis (PEP) at both the local and national levels. Organizations are training health care providers in PEP provision, and the project has established a coordinated program with integrated post-rape services provided by pharmacists, police, and social workers.

Prevention of Mother-to-Child transmission (PMTCT)

PMTCT services have proven to reduce dramatically the transmission of the virus from an HIV-positive mother to her child during pregnancy, labor and delivery, and breastfeeding. The positive impact of PMTCT is tremendous but there are significant barriers that stand in the way of women's access and use of such services. Women do not always have access to adequate antenatal care or to information and counseling about HIV. There is also the fear of ostracism and domestic violence that lead to women's refusal to be tested or to not return for their results. Women are stigmatized if they avoid breastfeeding because infant formula feeding has become associated with being HIV positive. Finally, traditional social norms preclude men from getting involved in women's reproductive health and being supportive partners. But there are ways to address these problems.

Several health centers in Rwanda have initiated highly successful programs to engage men in PMTCT services. Partners are invited to accompany women to prenatal visits and receive voluntary counseling and testing. They participate in reproductive health services provided to their partners such as prenatal counseling. Associated community services work to change male attitudes and behaviors that compromise their own health as well as the health of women and children. The U.S. also supports PMTCT programs that encourage men's participation. For example, in Uganda, Kenya, and South Africa, programs have begun to initiate partner testing within PMTCT settings.

Importance of Research to Develop Microbicides

For many women, negotiating "A, B, or C" is not possible, or extremely difficult. "In Women's Hands," the film that we viewed today, provides a poignant portrayal of the social and economic environment that makes women vulnerable and the role that microbicides could have in protecting themselves and their families.

Microbicides offer the opportunity of a woman-controlled method for reducing her risk of HIV acquisition. USAID strongly supports the development of microbicides as one of several important methods to address this urgent and yet unmet need for protecting women in developing countries against HIV/AIDS.

Treatment

Women's access to treatment is influenced by financial, physical, and social factors. Some challenges we face with treatment are the cost of services and drugs, distance to a health facility, quality of care, and lack of decision-making power, in accessing and adhering to treatment. The USG recognizes the barriers that women and men selectively may face in adhering to treatment or receiving on-going care, creating bridge programs to draw traditionally excluded populations into care and treatment services, and incorporating, as appropriate, family-centered care.

Inheritance and Property Rights

Ownership and control over economic assets, such as housing and land, can protect women who are affected by HIV/AIDS from destitution. In fact, the newly updated National Security Strategy of the United States indicates that, "economic freedom is moral imperative." Furthermore, the Strategy states that "the liberty to create and build or to buy, sell and own property is fundamental to human nature and foundational to a free society."[16]

Many women who are widowed have little access to food or shelter. Supporting their property and inheritance rights addresses one of their greatest areas of vulnerability, providing the stability needed to raise children and take care of their own needs. These policies are either non-existent or not enforced in many developing countries. As a result, women are left completely vulnerable and their households may be destroyed without a right to property.

The Emergency Plan supports efforts to review, revise, and enforce laws relating to sexual violence and women's property and inheritance rights; enhance women's access to legal assistance, and; eliminate gender inequalities in civil and criminal codes. In Kenya, the USG supports the Federation for Women Lawyers which helps people living with HIV/AIDS on issues around property and inheritance as well as rape and sexual assault.

In Kenya, the U.S. has also supported a workshop with the Kenya National Commission for Human Rights to address the problem of women's inheritance and rights of property. The workshops provided an opportunity for elders, women leaders, political leaders, the provincial administration, and local and national organizations to explore the inheritance problem. The project organized eight participatory workshops where widows and orphans vividly described the experience of losing land and other inheritances. These educational workshops helped fundamentally to shift the power dynamics between the sexes and lessen the ignorance and distortion within the community, leading to a strong partnership in addressing the plight of women and orphans and vulnerable children. As a result,

more than 20 women and their children have been resettled back on their family lands.

Education

A disproportionate burden of care giving to people infected and affected by HIV/AIDS falls on women and girls because of their socially expected roles as caretakers. Girls are often forced to drop out of school in order to care for a parent or adult living with HIV/AIDS. Many children become orphans and have to fend for themselves, increasing their vulnerability to HIV/AIDS. Children become academically vulnerable if they leave school due to lack of time, money, and hope for the future. The U.S. has supported efforts to promote community involvement where household tasks are shared among partners and other community members.

The USG has education activities that support access to education for underserved populations, especially girls, orphans, and other vulnerable children in the midst of the HIV/AIDS epidemic. In Kenya and Zambia, we are working on strategic planning for a coordinated Ministry of Education response to HIV/AIDS. In South Africa, we are integrating HIV/AIDS training for communities and school governing bodies; forming linkages among NGOs concerned with nutrition, care of orphans, and VCT; and empowering and assisting teachers and parents to support vulnerable children. The "Life Choices" program in South Africa uses peer education as a vehicle to deliver prevention messages. Student leaders are nominated by their peers, trained on HIV/AIDS prevention, and serve as resources to their peers. In Zambia, the Bwafwano community project identifies orphans and vulnerable children and connects them to educational opportunities in both community- and government-run schools.

Microfinance

We support microfinance as a way to ensure more sustainable livelihoods for women and girls with HIV/AIDS. USAID has worked with AFRICAP Microfinance Fund on their goal of encouraging (and possibly requiring) their partners to have HIV/AIDS action plans and responses. In Uganda, FINCA provides loans to HIV/AIDS-affected families. The relationships between the Emergency Plan and microfinance programs are being strengthened. The U.S. is ramping up support for activities targeting income generation development for women, helping women to mitigate the impact of HIV/AIDS on themselves and their families.

Food security

The long-term effects of the HIV/AIDS epidemic have eroded the ability of households to produce food and other agricultural products, generate income, and care for and feed family members. Women play an enormous role in food security and if they can no longer contribute, then a household's ability to engage in food security is greatly debilitated. The central role of gender in household food security will be addressed in the design of all interventions.

Conclusion

Let me conclude by saying that through the Emergency Plan, as well as other complementary USAID programs, the agency is absolutely committed to bringing about real change in the lives of women and girls throughout the developing world. As an international development agency, addressing gender is an essential component of the work we do. Right now, we are enhancing our multi-sectoral approach to supporting HIV/AIDS programs in developing countries. This means that, in terms of the HIV/AIDS pandemic, we want to ensure cross-coordination between agriculture and food security; democracy and governance, including human rights; education; economic growth; and the health sector.

In addition, it is imperative that in the United States and in the international community generally, the acrimonious and counterproductive debate over the "ABC" prevention strategy must end. Too much is at stake to allow the partisan name calling on both sides to continue. We must understand that addressing gender disparities is key to facilitating the "ABC" behaviors that are essential to prevent the continued spread of HIV in most parts of the world. In short, there will be no way to reduce significantly the incidence, and eventually prevalence, rates of HIV without addressing human rights, gender equity, and the task of ending sexual violence and coercion which fuel so much of the spread of HIV/AIDS. On this a broad base of consensus can be formed, and on this we must focus our attention.

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